If Wishes Were Horses, Inc
A non-profit 501 (c) (3), therapeutic riding program
Fleet Equestrian Center, LLC
2142 Hicklin Bridge Rd Edgemoor, SC 29712

Information for Physician and Prescrition to ride page 1 of 2

Client Name____ DOB_____________________

Parent/Guardian ____ Phone________________

The following conditions, if present, may represent precautions or contradictions to therapeutic riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree (Circle and comment if needed).

Orthopedic	**Medical/ Surgical**	**Secondary Concerns**
Spinal Fusion	Cancer	Behavioral Problems
Spinal Instabilities / Abnormalities	Poor Endurance	Age under Two years
Atlantoaxial Instabilities	Recent Surgery	Age Two-Four years
Scoliosis	Diabetes	Acute Exacerbation of -
Kyphosis	Peripheral Vascular Disease	Chronic Disorder
Lordosis	Varicose Veins	Indwelling Catheter
Hip Subluxation and Dislocation	Hemophilia	
Osteoporosis	Serious Heart Condition	**Neurological**
Pathologic Fractures	Stroke/CVA	Hydrocephalus/shunt
Coaxes Arthrosis		Spina Bifida
Heterotopic Ossification		Tethered Cord
Osteogenesis Imperfecta		Chiari II Malformation
Spinal Orthoses		Hydromyelia Paralysis
Cranial Deficits		Due to Spinal Cord Injury
Internal Spinal Stabilization Devices		Seizure Disorders
Areas of Concern	**Areas of Concern**	**Mobility Level**
Auditory	Orthopedic	Independent Ambulation
Visual	Allergies	Crutches
Speech	Learning Disabilities	Braces
Cardiac	Neurological	Wheelchair
Circulatory	Mental Impairment	Other
Pulmonary	Psychological	
Muscular	Other	

Comments____
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Information for Physician and Prescription to Ride page 2 of 2

Client Name ______________________________________DOB __________Age _______

Diagnosis/Problem ____

Precautions for this diagnosis/problem____

____

Any Past Surgeries to date? ___ Yes ___No Future Surgeries? ___ Yes ___No

Type of surgery/Related precautions____

____

********************** **For Persons with Down Syndrome only**************************

Cervical X-ray for Atlantoaxial Instability Date of X-ray __________________

___Positive ___Negative for signs of Atlantoaxial Instability.

**************************For Persons with Seizures only******************************

Height ______ Weight ______ Seizure Type _______________ Controlled __Y __N Date of Last Seizure ________

Seizure Medications____

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Licensed Medical Professional Rx

I recommend horseback riding for _____________________________________ (client name) as an activity that could provide benefits to their health, wellness, and enjoyment of life. I find horseback riding to be safe activity in which the stated client can participate, while supervised.

To my knowledge there is no reason this person cannot participate in therapeutic horseback riding. However, I understand that the therapeutic riding center will weigh the medical information against the existing precautions and contradictions of PATH Intl standards.

Medical Professional's Signature ____________________________________Title______

Medical Professional's Name (print) ____

Office Phone____________________ Office Name____________________________________

Date _______________ City_________________________ State __________________